

Healthcare Workforce 5th Grade Contest Entry Form

Must be included with the submitted entry

Student Name: _____ Grade: _____

School: _____

School Address: _____

City/Town: _____ Zip Code: _____

School Phone Number: _____

Teacher: _____ Teacher email: _____

All entries will become the property of the South Dakota Department of Health (DOH) and may be displayed or reproduced in publications of the DOH at the Department's discretion.

Contest submissions will not be returned.

Names, grades and the schools of contest entrants will be made available to the judges of the contest. This information will also be acknowledged in any display or reproduction of the materials.

Parents: If you consent to having your child submit an entry to this contest please complete and sign this Consent to Participate.

Consent to Participate:

I, being the parent/legal guardian of the student named below, have read and understand the information provided on this form. I voluntarily consent to my child's participation in the above named contest under the terms and conditions stated on this form and as described on the contest information brochure.

Full Name of Student (please print)

School

Name of Parent/Guardian (please print)

Signature of Parent/Guardian

Date: _____